

Policy Title: Mental Capacity Act 2005 and Deprivation of Liberty Policy
Policy Number: SWLCCG/CL06

	Name	Role and Organisation	Date
Author	Fergus Keegan	Director of Quality	Jan 2020
Reviewers	Marino Latour & Sarah Loades	Designated Nurses for Safeguarding Adults	May 2020
Authoriser	Sarah Blow	SWL CCG Senior Management Team	May 2020

Approved By	Senior Management Team
Applies To	South West London CCG (SWL CCG), Governing Body Members, Committee Members and all staff working for, or on behalf of, NHS South West London CCG.

Effective Date	01/04/2020
Review Date	01/04/2021

Controlled Document

The current version of this document is always available electronically via SharePoint or the intranet. All other electronic or paper versions of this document sourced from any network drive, email or other sources are uncontrolled and should be checked against the current SharePoint or intranet version prior to use.

Target Audience	South West London CCG (SWL CCG), Governing Body Members, Committee Members and all staff working for South West London CCG, or the associated Health and Care Partnership (HCP)
Brief Description	This policy outlines how SWL Clinical Commissioning Group (CCG), as a commissioning organisation, will fulfil its legal duties and statutory responsibilities within the organisation and across the health economy in South West London. The purpose of the Policy is to ensure that robust structures, systems and quality standards are in place to comply with the requirements of the Mental Capacity Act 2005 (including the Deprivation of Liberty Safeguards (DoLS) and Community Deprivation of Liberty Authorisations).
Action Required	Following ratification at the CCG Governing Body, the Accountable Officer (through the Chief Nurse and Executive Director of Quality South West London, supported by each of the Place Based Leaders/ Executive Locality Directors) will ensure that:

- | | |
|--|--|
| | <ul style="list-style-type: none">• the requirements of this policy will be raised at all team meetings, confirming the requirements with the Chairs of each Committee and each of the Clinical Commissioning Group Executive Directors.• The Chief of Staff South West London will establish and maintain a corporate register of all policies and their status, and will ensure that these are appropriately reflected on the website.• All members of CCG staff will ensure they are aware of their responsibilities in relation to the Policy and adhere to the requirements of the Policy as it relates to their role.• CCGs are statutorily responsible for ensuring that the organisations from which it commissions services provide a safe system which safeguards adults at risks, including adults who lack mental capacity. The CCG will therefore ensure that they commission MCA 2005 compliant services.• CCGs are responsible for monitoring the Mental Capacity Act (Amendment) 2019 update and the implementation of Liberty Protection Safeguards (LPS) which will replace DoLS following the publication of the Code of Practice (October 2020).• CCG will also ensure that training is delivered and received to all staff members. |
|--|--|

DRAFT

Contents

1. Introduction	4
2. Policy Statement	4
2.1 Legal, Statutory, Mandatory, and Best Practice Requirements	4
3. Scope	5
4. Definitions	6
5. Duties and Responsibilities	8
6. Five Principles	10
6.1 Consent to care and treatment	11
6.2 The two-stage test of capacity	11
6.3 The four-part functional test	11
7. Best Interests	12
7.1 Best Interest Checklists	12
7.2 Protection for Actions	12
8. Advance Decision to Refuse Medical Treatment (ADRMT)	12
9. Lasting Power of Attorney (LPA) for Health and Welfare	13
10. Restraint and Restriction	13
11. Deprivation of Liberty	13
12. Independent Mental Capacity Advocates (IMCA)	14
13. Review	15
14. Templates/Forms	15
15. Internal and External References	15
15.1 Internal References	15
15.2 External References	15
16. Monitoring	16
17. Equality Impact Assessment	17
18. Change History	17
Appendix 1 MCA 2005 Decision Making Flow Chart	18
Appendix 2 Procedural Intervention - Assessing Capacity	19
Appendix 3 Procedural Intervention - Wishes and Authorisations	21
Appendix 4 Procedural Intervention - Best Interests	22
Appendix 5 Equality Impact Assessment	23

1. Introduction

The Mental Capacity Act (MCA) 2005 creates a legal framework to support and protect people who lack or have reduced capacity to make specific decisions at the time those decisions need to be made.

The MCA applies to all people over the age of 16 across England and Wales, with the exception of making a Lasting Power of Attorney (LPA); making an advance decision to refuse treatment (ADRT) and being authorised under the Deprivation of Liberty Safeguards. In these situations, MCA applies when a person is aged 18 or over.

The MCA contains provisions for assessing whether a person has the mental capacity to make a specific decision and, if they do not, how to make a decision on their behalf and in their best interests.

The MCA is supported by the Code of Practice 2007 which was updated in January 2016. The Code of Practice provides guidance to anyone who is working with/or caring for adults who may lack capacity to make particular decisions. It describes their responsibilities when acting or making decisions on behalf of individuals who lack the capacity to act or make these decisions for themselves.

2. Policy Statement

The purpose of this policy is to set out the roles and responsibilities of the CCG (as a commissioning body), its employees and those providers from whom it commissions services, to comply with the requirements of the MCA.

2.1 Legal, Statutory, Mandatory, and Best Practice Requirements

- Cabinet Office (1998) Human Rights Act 1998. London. HMSO.
- Cabinet Office (2000) Freedom of Information Act 2000. London. HMSO.
- Cabinet Office (2005) Mental Capacity Act 2005. London. HMSO.
- Cabinet Office (2006) Equality Act 2006. London. HMSO.
- Cabinet Office (2007) Mental Health Act 2007. London. HMSO.
- Health and Safety Executive (1974) Health and Safety at Work etc. Act 1974. London. HMSO.
- Cabinet Office (1983) Mental Health Act 1983. London. HMSO
- Cabinet Office (2005) Mental Capacity Act 2005. London. HMSO.
- Cabinet Office (2007) Mental Health Act 2007. London. HMSO
- Department of Health (2007) Mental Capacity Act 2005: Deprivation of liberty safeguards - Code of Practice to supplement the main Mental Capacity Act 2005 Code of Practice. London. DH.
- Department of Health (2009) The Mental Capacity Act Deprivation of Liberty Safeguards. London. DH.
- Griffiths, Rachel and Leighton, John (November 2012) Adults' Service SCIE Report 62. Managing the transfer of responsibilities under the Deprivation of Liberty Safeguards: a resource for local authorities and healthcare Commissioners. London: Social Care Institute for Excellence.
- Health and Safety Executive (1974) Health and Safety at Work etc. Act 1974. London. HMSO.
- House of Lords (March 2014) Select Committee on the Mental Capacity Act 2005: Post-legislative scrutiny. London: The Stationery Office.
- Cheshire West Judgement 2014.

3. Scope

This policy applies to all staff employed by the CCG, including any agency, self-employed or temporary staff.

All managers must ensure their staff are made aware of this policy and how to access it and ensure its implementation within their line of responsibility and accountability. This is a corporate policy and applies to all employees of the CCG, in particular:

- General Practitioners, acting as representatives;
- Staff working in Continuing Healthcare (CHC) who visit patients, their families and carers; and
- Staff who are responsible for commissioning NHS funded nursing care and NHS CHC.

The SWL Clinical Commissioning Group will inform:

- Other commissioners of care and treatment services about any safeguarding concerns arising from a failure to comply with the Act; and
- The police if it has reason to believe a crime has been committed under section 44 of the MCA (the ill treatment or willful neglect of an adult who lacks capacity).

The purpose of this policy is to support the CCG in discharging its duties and responsibilities in regard to the MCA 2005. This requires the CCG to understand and be able to apply the principles of the MCA Code of Practice and the Deprivation of Liberty Safeguards (DoLS) Code of Practice. Therefore the CCG can be assured that assessments of capacity are carried out appropriately by commissioned services and that decisions made on behalf of people who lack capacity are made in their best interests.

Commissioned services are expected to demonstrate compliance with both Codes of Practice and any legal changes as a result of case law.

The MCA applies to all people over the age of 16 across England and Wales, with the exception of making a Lasting Power of Attorney (LPA); making an Advance Decision to Refuse Treatment (ADRT) and being authorised under the Deprivation of Liberty Safeguards. In these situations, the MCA applies when a person is aged 18 or over.

The MCA also introduces several bodies and regulations that staff must be aware of, including:

- The Independent Mental Capacity Advocate (IMCA)
- The Office of the Public Guardian (OPG)
- The Court of Protection (CoP)
- Advance Decisions to Refuse Treatment (ADRT)
- Lasting Powers of Attorney. (LPA)

The MCA protects organisations, providers and families from liability, allowing necessary care and treatment to take place just as if the person who lacks capacity has consented to them. The action is legally in the person's best interests. Practitioners are required to:

- Observe the principles of the MCA;
- Make assessment of capacity and it is reasonably believed that the person lacks capacity in relation to the matter in question;
- Have a reasonable belief that the action taken is in the best interests of the person.

4. Definitions

Advance Decision to Refuse Medical Treatment (ADRT)

An ADRT is a decision made by a person who is 18 years of age or more and who has capacity, to refuse particular medical treatment in advance. As long as it is valid and applicable to the circumstances under which it is being considered, it has the same effect as a contemporaneous refusal of treatment by an adult with capacity.

Attorney

An attorney is a person who has been appointed under a Lasting Power of Attorney or (prior to October 2007) an Enduring Power of Attorney. An attorney has the legal right to make decisions on behalf of the donor who appoints them, providing these decisions are within the scope of their authority.

Best interests

Any act done or decision made on behalf of a person who lacks capacity must be done or made in their best interests. Section 4 of the Act sets out a non-exhaustive checklist to help you work out a person's best interests.

Best interests decision-maker

A best interests decision maker is the person who is responsible for deciding what is in the best interests of a person who lacks capacity.

Capacity

Capacity is concerned with someone's ability to make a decision about a particular matter at the time the decision needs to be made.

Court of Protection

The Court of Protection is a specialist court for all issues relating to people who lack capacity to make specific decisions. It makes decisions and appoints deputies.

Decision maker

The person who is responsible for deciding what is in the best interests of a person who lacks capacity.

Deprivation of liberty

Liberty is a human right. A person cannot be deprived of their liberty under the MCA 2005 unless it has been authorised either by the Court of Protection, under the Deprivation of Liberty Safeguards procedure, or is to give effect to life-sustaining or other emergency treatment while a decision on any relevant matter is being sought from the Court.

Deprivation of Liberty Safeguards (DoLS)

In care home and hospital settings, the DoLS are used to authorise the deprivation of liberty of people who are 18 years of age or more, who lack capacity to consent to arrangements for their care or treatment in their best interests. It applies equally to people who are self-funded and publicly-funded (liberty is a

universal human right). If a person who is funded by the CCG and who lacks capacity in the community, a Community DoLS application needs to be made to the Court of Protection for authorisation.

Donor

A donor is the person who makes a Lasting Power of Attorney to appoint one or more attorneys to manage their property and financial affairs or to make decisions about their health and welfare. A donor is also a person who made an Enduring Power of Attorney prior to October 2007.

European Convention 1950

The European Convention on Human Rights 1950. An example of a human right is the right to liberty and security of person.

General Data Protection Regulation (GDPR) (2018)

The GDPR is the legal framework that sets guidelines on the collection of processing of personal individuals who live in the European Union (EU)

Health and Welfare Lasting Power of Attorney

A Health and Welfare Lasting Power of Attorney allows the attorney(s) appointed to make decisions about the donor's personal welfare (including healthcare).

Independent Mental Capacity Advocate (IMCA)

This is an advocate who supports and represents a person who lacks capacity to make important decisions, who has no one else appropriate and willing to support them. They make sure that major decisions for a person who lacks capacity are made in accordance with the Act.

Lasting Power of Attorney (LPA)

A Lasting Power of Attorney is a legal document. It enables an adult who is 18 years of age or more and who has capacity (the donor) to appoint one or more attorneys to make decisions on their behalf. An LPA must be registered with the Office of the Public Guardian before it can be used.

Mental Capacity Act 2005 (MCA)

The Act governs decision-making on behalf of people who lack capacity, in England and Wales.

Mental Capacity Act Code of Practice

The Code offers practical guidance, explains how the Act operates on a day to day basis and gives examples of best practice. You are under a duty to have regard to the Code when making any decision or taking any action on behalf of people who lack capacity to make a decision for themselves.

Restraint

Restraint / restriction under the MCA is :

- the use of, or threat to use, force to secure the doing of an act which the person resists; or
- restricting their liberty of movement, whether or not they resist.

For restraint to be lawful, the MCA requires it to be:

- necessary to prevent harm to the person who lacks capacity; and
- a proportionate response to the likelihood of the person suffering harm, and the seriousness of that harm.

The act of restraint must be in proportion to the *harm* that would otherwise occur to the person, rather than to the *outcome* that the restraint is designed to achieve. Only the minimum amount of restraint for the shortest possible time should be used to prevent harm occurring (harm is likely to include psychological as well as physical harm).

Restriction of liberty

Actions that amount to a mere restriction of liberty but fall short of a deprivation of liberty may be performed lawfully under section 6 of the MCA if certain conditions are met. Practitioners must be aware that the cumulative effect of a number of restrictions could amount to a deprivation of liberty (what matters is the degree and intensity of the restrictive measures).

Serious medical treatment

Serious medical treatment, in the context of instructing an IMCA, means:

- giving new treatment
- stopping treatment that has already started
- withholding treatment that could be offered in circumstances where there is a fine balance between the likely benefits and burdens to a patient, and the risks involved, if a single treatment is being proposed; a decision between a choice of treatments is finely balanced; or the treatment being proposed is likely to have serious consequences for a patient (for example, treatments which cause serious and prolonged pain, distress or side effects, will have a serious impact on the patient or their future life choices).

Examples of serious medical treatment include chemotherapy, surgery for cancer and treatments which will result in permanent loss of sight or hearing.

5. Duties and Responsibilities

Governing Body

The CCG has delegated responsibility to the Governing Body for setting the strategic context in which organisational process documents are developed, and for establishing a scheme of governance for the formal review and approval of such documents.

The Accountable Officer

The Accountable Officer has overall responsibility for the strategic direction and operational management, including ensuring that process documents comply with all legal, statutory and good practice guidance requirements.

The Accountable Officer is accountable for ensuring that the health contribution to the MCA and DoLS is discharged effectively across the whole local health economy through CCG commissioning arrangements. This role is supported by the Chief Nurse and Executive Director of Quality, who is the Executive lead for the MCA, who in turn is supported by the Designated Nurses for expert advice to the Governing Body on MCA and MCA DoLS matters.

The Chief Nurse and Executive Director of Quality

The CCG Chief Nurse and Executive Director of Quality, as Executive Lead for the MCA and DoLS will, with support from the Designated Nurses, ensure SWL CCG has effective staffing, systems, processes and structures in place, ensuring that there is a programme of training and mentoring to support staff within the CCG. The Chief Nurse and Executive Director of Quality is responsible for ensuring that:

- This policy is drafted, approved and disseminated.
- The necessary training required to implement this document is identified and resourced.
- Mechanisms are in place for the regular evaluation of the implementation and effectiveness of this document.
- The Accountable Officer and governing body members are made aware of any concerns relating to a commissioned service.
- The CCG has in place assurance processes to ensure compliance with the MCA and DoLS legislation, guidance, policy, procedures, Codes of Practice, quality standards, and contract monitoring of providers.

Designated Nurses for Safeguarding Adults

The Designated Nurses for Safeguarding Adults are the designated professionals with strategic and professional leadership for the MCA within the CCG. They will ensure that the MCA and DoLS is embedded in the Safeguarding and Quality strategy across the health economy. They will raise the profile of the MCA and the DoLS to ensure they are understood and effectively implemented in our local health services.

Designated Nurses for Safeguarding Adults will:

- Work with the Chief Nurse and Executive Director of Quality to ensure robust assurance arrangements are in place within the CCG and provider services.
- Provide advice and expertise to the CCG's Governing Body and associated groups and to professionals across both the NHS and partner agencies.
- Work jointly with the local authorities being responsible for providing support and advice to clinicians in individual cases and supervision to staff in areas where these issues may be particularly prevalent and/or complex.
- Provide professional leadership, advice and support to lead professionals across provider trusts/ services and independent contractors.
- Represent the CCG on relevant committees, networks and multiagency groups charged with responsibility for leadership, oversight and implementation of the MCA and DoLS.
- Lead and support the development of the MCA and the DoLS policy and procedures in the CCG in accordance with national, regional and local requirements.
- Provide advice and guidance in relation to MCA, DoLS training including standards.
- Ensure quality standards for the MCA and DoLS are developed and included in all provider contracts and compliance is evidenced.
- Work closely with the Designated Nurses for Safeguarding Children and Designated Looked After Children to ensure that where appropriate, there is effective information flow across both children and adults' safeguarding services.

Managers and Executive Leads

Managers and Executive leads have responsibility for:

- Ensuring they are aware of and carry out their responsibilities in relation to the MCA and DoLS.
- Ensuring that the MCA and DoLS policy is implemented in their area of practice.

- Ensuring staff are aware of the contact details of the CCG Safeguarding Team for any issues of concern regarding care or commissioning practice relating to the MCA and DoLS.
- Ensuring that all CCG staff undertakes mandatory MCA and DoLS training commensurate to their role, as set out within the Safeguarding policy training section.

CCG Staff

All staff, including temporary and agency staff, are responsible for actively co-operating with managers in the application of this policy to enable the CCG to discharge its legal obligations. In particular, staff are responsible for:

- Complying with the MCA and DoLS Policy.
- Ensuring they familiarise themselves with their role and responsibility in relation to the Policy.
- Identifying training needs in respect of the Policy and informing their line manager.

Continuing Healthcare (CHC) Employees

CHC employees are responsible for:

- attending training on the MCA
- being familiar with the principles and practice of the MCA
- promoting the use of ADRT and LPA when appropriate
- understanding the principles of confidentiality and information sharing in line with the MCA, the Data Protection Act 2018, the GDPR and wider professional obligations
- Contributing to best interests meetings when related to CHC funded individuals.
- completing assessments of capacity (if necessary) when assessing or reviewing persons for Funded Nursing Care or CHC;
- acting as the best interests' decision maker when appropriate
- referring patients to an advocacy service as required
- ensuring that decisions made in a person's best interest are clearly documented; and
- Alerting safeguarding professionals in the Local Authority if they suspect abuse or neglect of a person without capacity.

Primary Medical Services (GP practices)

GP practices are informed of the Standard NHS Contract standards and encouraged to take account of these. The CCG, in partnership with NHS England and supported by North East London Commissioning Support Unit (NELCSU), will develop a programme to support and monitor the adoption and implementation of the MCA and DoLS in GP practices.

6. Five Principles

1. The presumption of capacity – every adult has the right to make their own decisions and must be assumed to have capacity to do so unless it is proved otherwise. You cannot assume that someone cannot make a decision for themselves just because they have a particular medical condition or disability.
2. All practicable steps must be taken to support individuals to make their own decisions – the person must be provided with all the relevant information to make the decision before it can be concluded that the person is unable to make that decision.
3. Right to make an unwise decision- it is every person's fundamental right to make an unwise or erratic decision and that everyone's beliefs and values, preferences should not be regarded as the

same as everyone else's. Making an unwise or erratic decision cannot be regarded as evidence of a lack of capacity.

4. Best interest – all decisions made on behalf of a person that lacks capacity should be made in their best interests.
5. Least restrictive option – all decision made for the person who lacks capacity should incorporate interventions that are least restrictive.

6.1 Consent to care and treatment

Gaining informed consent to care and treatment is fundamental to the legal and professional obligations of health and social care practitioners and to the human rights of individuals. Supported decision making is important to the process of informed consent – particularly where a person is not able to verbalise their views, make their choice and decision clear or when they have variable conditions which may result in fluctuating capacity.

Obtaining informed consent is not always easy and the individual may need a range of different support in order to give informed consent.

6.2 The two-stage test of capacity

1. Is there an impairment or a disturbance in the functioning of the person's mind or brain?
2. Is the impairment or disturbance sufficient that the person lacks the capacity to make a particular decision?

A lack of mental capacity could be due to:

- Dementia
- significant learning disability
- brain injury
- concussion following a head injury
- the effects of a stroke
- brain tumors
- physical and medical conditions that cause confusion, drowsiness or loss of consciousness
- neurological disorder
- conditions associated with some forms of mental illness
- delirium
- the effects of drug or alcohol use.

6.3 The four-part functional test

The MCA states that a person is unable to make their own decision if they cannot do one or more of the following four things:

- understand relevant information about the decision to be made;
- retain that information in their mind long enough to make the decision themselves;
- use or weigh up that information as part of the decision-making process; or
- communicate their decision by any means.

7. Best Interests

Where a person lacks mental capacity to consent to care and treatment (including restraint and deprivation of liberty), and there are no other legal provisions for decisions to be made on their behalf, decisions regarding care and treatment must be made under Best Interests principles. The MCA does not define what would or could be in the best interest of an individual – as the whole purpose of the MCA and its Code of Practice, is to promote person-centred care, protect the rights of individuals and ensure the right decisions are made for individuals at specific times. Rather, it sets out a process for Best Interest decisions about care and treatment which are based on the needs, wishes and choices of the individual person - not the desired outcome of professionals.

7.1 Best Interest Checklists

The process of making a Best Interest's decision should involve a range of people, including the person who lacks mental capacity, their family/friends and/or advocates. The Best Interest principles should lead to more collaborative, comprehensive, better informed and person-centred care and treatment. Decisions should still be made based on less restrictive care, minimal invasive treatment and the most aligned to the known wishes of the person – whether this is in regard to serious medical treatments, the restriction, restraint or deprivation of liberty for the purposes of care or for discharge/changes to long term accommodation and care. The below should be considered as a best interest checklist:

1. Avoid making assumptions based on age, appearance, condition or behavior.
2. Consider a person's own known wishes, values, beliefs. Take account of the views of family and informal carers regarding the care and treatment.
3. Consider if the decision can be delayed until the person regains capacity.
4. Involve the person in decision-making, even if they lack capacity to consent.
5. Demonstrate that all views and evidence have been considered – if there is conflict.
6. Provide clear objective reasons to support why a decision is in the person's best interest.
7. Take account of any IMCA involved. Take the less restrictive alternative or intervention.

7.2 Protection for Actions

Staff are legally protected if they perform an act of care or treatment in the best interests of a person, even though the person lacks capacity to give their consent to it. This statutory protection does not apply to any act giving rise to civil liability for negligence or to any criminal liability.

8. Advance Decision to Refuse Medical Treatment (ADRMT)

A person who is 18 years of age or over and has capacity, can refuse specified medical treatment. A person making an advance decision:

- must be 18 years of age and over; and
- must have the capacity to make an advance decision.

An advance decision must:

- exist (in some cases, this may exist verbally);
- be valid (for example, the person has not withdrawn the advance decision when they had capacity to do so); and
- be applicable to the circumstances under which it is being considered.

An advance decision to refuse life-sustaining treatment must:

- be in writing;
- be signed by the person making it and witnessed; and
- contain the words “*even if life is at risk*”. If these words are contained in a separate document, that document must also be signed and witnessed.

9. Lasting Power of Attorney (LPA) for Health and Welfare

A person who lacks capacity may have appointed a Lasting Power of Attorney for Health & Welfare (LPA). This person(s) may have legally binding powers to make decisions on behalf of an individual, regarding medical care and treatment, including life-sustaining treatment, ongoing care provision, long-term changes to a care setting and any issues/complaints/safeguarding concerns regarding care provided.

Nurses and other health and social care practitioners need to ascertain if an individual has anyone nominated as an Attorney for Health & Welfare under a LPA, as these people play a vital and legal role and are likely to be the ‘decision-maker’ for the clinical decisions of people unable to consent to care and treatment themselves; they need to be involved in all clinical decisions and their opinion and decision sought by the clinical team and clinical decision-maker. Professionals need to satisfy themselves that the LPA is registered by the Office of the Public Guardian and need to identify the scope of the powers donated

10. Restraint and Restriction

Restraint and restriction are:

- the use of, or threat to use, force to secure the doing of an act which the person resists; or
- restricting their liberty of movement, whether or not they resist.

For restraint to be lawful, MCA requires it to be:

- necessary to prevent harm to the person who lacks capacity; and
- a proportionate response to the likelihood of the person suffering harm, and the seriousness of that harm.

The act of restraint must be in proportion to the *harm* that would otherwise occur to the person, rather than to the *outcome* that the restraint is designed to achieve.

Only the minimum amount of restraint for the shortest possible time should be used to prevent harm occurring (harm is likely to include psychological as well as physical harm).

Restricting a person’s freedom of movement does not necessarily require the application of force, however small. Restricting a person’s liberty is not the same as depriving a person of their liberty. Nothing in the MCA Code of Practice allows one person to deprive another person of their liberty, unless this has been specifically authorised first (for example, by the Court of Protection). This is because liberty is a human right and, if it is to be curtailed, it must be done strictly in accordance with a lawful procedure.

11. Deprivation of Liberty

In some instances, care or treatment in hospitals and care homes will be administered in circumstances which are so restrictive that they unavoidably deprive the person of their liberty in breach of their rights under Article 5 European Convention on Human Rights. This will be in situations where the person lacks capacity to consent to the measures being taken and where the measures being taken in the person’s best interests are in order to keep them safe.

In order to lawfully provide the care and treatment in these circumstances, the care provider will need to obtain legal authorisation which protects the patient's Article 5 rights.

A person is deprived of their liberty in relation to the arrangements made, or proposed, for their care or treatment if they:

- Are under continuous supervision and control (all three aspects are necessary);
- Are not free to leave, in the sense of moving to a place of their choice, to live with whomever they want.
- Lack capacity to consent to the arrangements for their treatment or care (for example, in the hospital or care home, in circumstances that amount to a deprivation of their liberty).

In hospital and care home settings, the Deprivation of Liberty Safeguards (DoLS) process is the legal framework to authorise a deprivation of liberty of people who are 18 years of age or more and who lack mental capacity to consent to the arrangements of where their care or treatment is provided. In other settings (for example, supported living in the community), this must be authorised by the Court of Protection. It applies equally to people who are self-funded and publicly-funded (liberty is a universal human right).

The DoLS are part of the MCA 2005; the safeguards aim to make sure that people in care homes and hospitals are looked after in a way that does not inappropriately restrict their freedom.

Where a person is in receipt of NHS CHC, and they lack mental capacity to consent to their accommodation, or care and support arrangements, the CCG responsible must ensure that the arrangements they commission are lawful and compliant with the MCA. Therefore where the person is placed in a care home or they are in hospital and they are subject to restrictions that constitute a deprivation of their liberty; the care provider (Managing Authority) must request authorisation from the relevant Local Authority (Supervisory Body) or in some specific circumstances, the Court of Protection for this deprivation of liberty.

Where the person who lacks capacity is in receipt of NHS CHC in their own home, including tenancy-based accommodation (for example, supported living), and is deprived of their liberty, this cannot be authorised using the DoLS process. The responsible CCG, as the primary funding authority, is responsible for applying to the Court of Protection for authorisation.

12. Independent Mental Capacity Advocates (IMCA)

An IMCA will support and represent a person who lacks capacity to make certain important decisions. An IMCA is an important safeguard for people who lack capacity but who have little or no network of support, and therefore nobody whom it would be appropriate for an assessor or best interests decision-maker to consult.

An IMCA must be instructed, and then consulted, when certain criteria are met. These are:

- a person is 16 years of age or more;
- they lack capacity to make a decision about the provision, withholding or stopping of serious medical treatment by an NHS body; or the arrangement of accommodation (or a change of accommodation) in a hospital or care home by an NHS body or local authority and
- they will stay in hospital for longer than 28 days or stay in the care home for more than 8 weeks; and
- there is no-one who is willing, able and considered by the assessor to be appropriate to consult on this specific decision (there is no relative, friend or unpaid carer, attorney appointed under a lasting

power of attorney or an enduring power of attorney, court-appointed deputy or an individual named by them to consult on this decision or decisions of this nature).

Where an IMCA has been appointed, they have a right to see the person in private and view parts of the person's healthcare records that are relevant to the decision in question; they will:

- support and represent the person in the decision-making process;
- ascertain the person's wishes, feelings, beliefs and values;
- provide information to help the decision maker find out what is in the person's best interests;
- consider whether the proposed course of action restricts the person's rights and freedoms as little as possible; and
- ask questions or challenge a decision which they do not believe is in the best interests of the person.

13. Review

This policy has been reviewed in accordance with SWL CCGs' governance. This policy will be reviewed in accordance with the timescale specified at the time of approval.

Staff who become aware of any change which may affect this policy should advise their line manager as soon as possible. The Governing Body will then consider the need to review the policy or procedure outside of the agreed timescale for revision.

For ease of reference for reviewers or approval bodies, changes should be noted in the *Document Review Control Information* table on the front page of this document.

The policy will be reviewed annually and in accordance with:

- legislative changes, including the Mental Capacity (Amendment) Bill;
- best practice guidance, including a new MCA Code;
- significant incidents reported;
- new vulnerabilities;
- changes to organisational structure; and
- the introduction of new systems and processes.

14. Templates/Forms

N/A.

15. Internal and External References

15.1 Internal References

- Safeguarding Adults Policy
- Safeguarding Children's Policy

15.2 External References

The Office of the Public Guardian (OPG)

This exists to help protect people who lack capacity by setting up a register of Lasting Powers of Attorney; Court appointed Deputies; receiving reports from Attorneys acting under LPAs and from Deputies; and providing reports to the COP, as requested. The OPG can be contacted to carry out a search on three

registers which they maintain, these being registered LPAs, registered EPAs and the register of Court orders appointing Deputies. This is a free service.

Further information regarding the OPG including all the forms to make powers of Attorney, can be found by the following link: <http://www.publicguardian.gov.uk/>

The Court of Protection (CoP)

This is a specialist court for all issues relating to people who lack capacity to make specific decisions. The Court makes decisions and appoints Deputies to make decisions in the best interests of those who lack capacity to do so.

The Act provides for a CoP to make decisions in relation to the property and affairs and healthcare and personal welfare of adults (and children in a few cases) who lack capacity. The Court also has the power to make declarations about whether someone has the capacity to make a particular decision. The Court has the same powers, rights, privileges and authority in relation to mental capacity matters as the High Court. It is a superior Court of record and is able to set precedents (i.e. set examples to follow in future cases).

The Court of Protection has the powers to:

- decide whether a person has capacity to make a particular decision for themselves;
- make declarations, decisions or orders on financial or welfare matters affecting people who lack capacity to make such decisions;
- appoint deputies to make decisions for people lacking capacity to make those decisions;
- decide whether an LPA or EPA is valid; and remove deputies or attorneys who fail to carry out their duties; and
- hear cases concerning objections to register an LPA or EPA.

Details of the fees charged by the Court, and the circumstances in which the fees may be waived or remitted, are available from the Office of the Public Guardian. Further information regarding the Court of Protection can be accessed via the Office of the Public Guardian website and the following link:

<https://www.gov.uk/courts-tribunals/court-of-protection>

The CCG must ensure that all informal and formal internal mechanisms be exhausted before making any application to the Court of Protection. However, where an application is required, this must not be delayed. Advice and support for legal services should be sought from Chief of Staff, South West London, in consultation with the local Designated Safeguarding Adults Nurse.

16. Monitoring

To ensure the CCGs' compliance with this policy, the adult safeguarding team will audit a sample of CHC cases to ensure that:

- mental capacity assessments and best interest decisions are undertaken and recorded in line with the Act;
- referrals to the local IMCA service are being made;
- deprivations of liberty for people funded by CHC have been identified and authorised; and
- all CHC staff have relevant and current training in place.

If you have any suggestions for the improvement of this Policy, please contact the Chief Nurse and Executive Director of Quality with your suggestions, for consideration.

17. Equality Impact Assessment

An Equality Impact Assessment must be carried out as part of the development of each Policy. Please check the draft Assessment at Appendix 1 and amend it accordingly. All public authorities have a legal responsibility to assess their activities, and to set out how they will monitor any possible negative impact upon equality in terms of the protected characteristics of age, disability, gender, gender identity, marriage or civil partnership, pregnancy and maternity or paternity, race, religion or belief, and sexual orientation. If a negative impact is identified you will need to take action to reduce that impact.

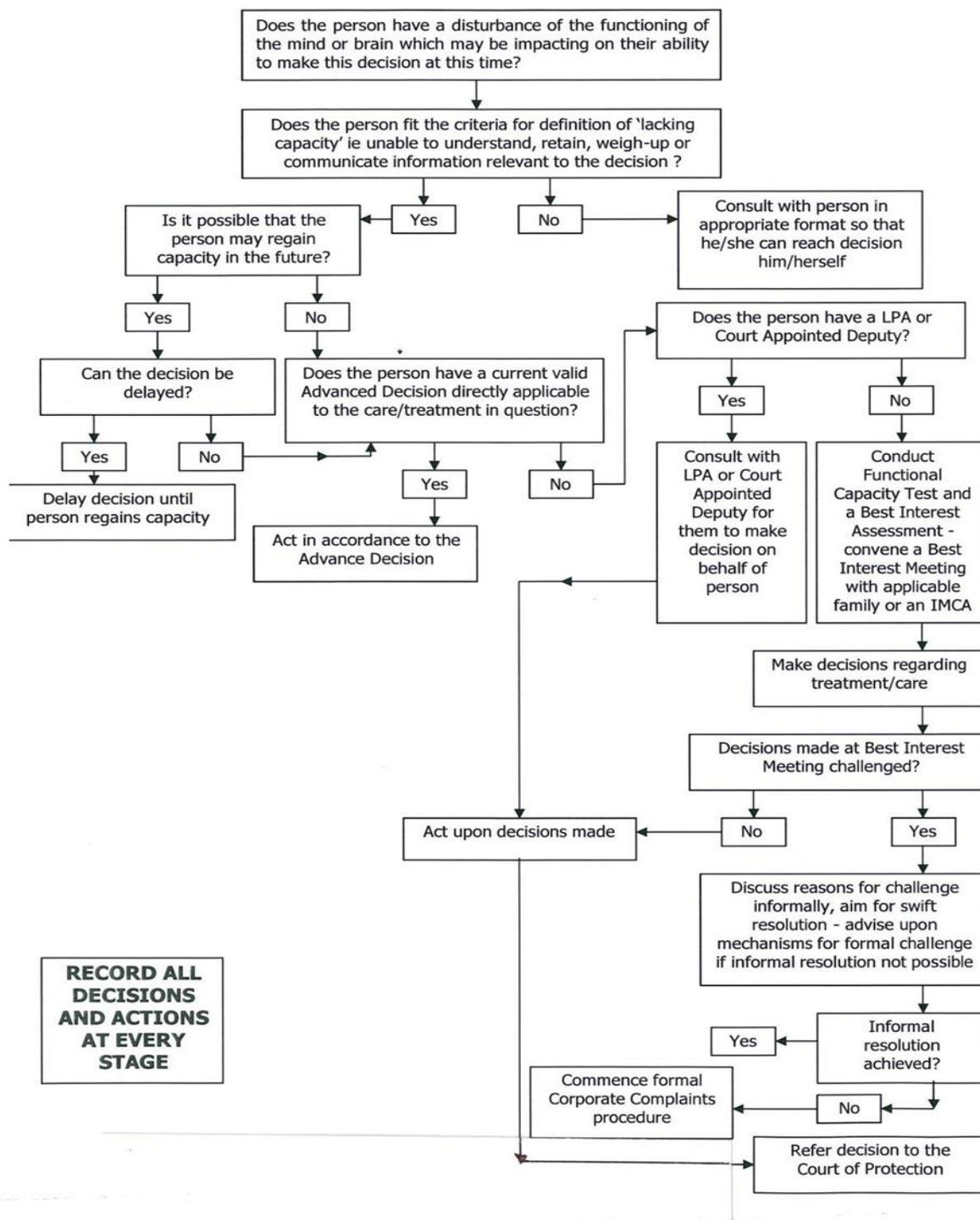
An Equality Impact Assessment has been completed for this Policy (Appendix 1), and no negative impact upon persons with protected characteristics has been identified.

18. Change History

Policy Number	Effective Date	Significant Changes
0.1	01/04/2020	Document creation

DRAFT

Appendix 1 MCA 2005 Decision Making Flow Chart



Appendix 2 Procedural Intervention - Assessing Capacity

Has the specific decision been clearly recorded? Capacity is a person's ability to make a particular decision or to take a particular action for themselves at the time the decision or action needs to be taken.

If the person is required to make more than one decision, have these been described separately? Capacity is decision specific. If a decision is made up of a number of smaller (perhaps linked) decisions, the assessor needs to break these down for the person.

Is the decision an excluded decision under the MCA 2005? Certain types of decision, such as a decision about voting, consenting to marriage or civil partnership, or consenting to sexual relations, are excluded under the MCA 2005.

Has the assessor recorded why they doubt the person's capacity to make the particular decision? A person's behaviour or circumstances may cause doubt about whether they have the capacity to make a particular decision. Somebody else may say they are concerned about a person's capacity. The person may have previously been diagnosed with an impairment or disturbance that affects the way their mind or brain works and it has already been shown they lack capacity to make other decisions in their life.

Is the assessor the correct person to carry out the assessment? The assessor should be the person who is responsible for carrying out the particular medical or related treatment to which the decision relates.

Does the person meet the age threshold for the MCA 2005? The test for capacity under the MCA 2005 applies to adults who are 16 years of age or more.

Has the assessor recorded the steps taken to help and support the person to make a decision, without success? A person should not be treated as being unable to make the decision until all practicable steps to help and support them to do so have been taken, without success. The assessor should offer whatever help and support is possible and appropriate, bearing in mind the person's individual circumstances, the nature of the decision and the time available to make it.

Has the assessor provided the person with information relevant to the decision, in a way that is appropriate to their circumstances, avoiding the blank canvas (assessment devoid of relevant information) approach? It is important not to assess a person's understanding before they have been given relevant information about the decision. Relevant information includes what the likely consequences of a decision would be (the possible effects of deciding one way or another), and also the likely consequences of making no decision at all. It is inappropriate to start from a blank canvas.

Has the assessor has taken specific cultural, ethnic and religious factors and values into account, when presenting information to the person? It is important to be aware of cultural, ethnic or religious factors that shape a person's way of thinking, behaviour or communication. For example, in some cultures it is important to involve the community in decision-making. Some religious beliefs may influence the person's approach to medical treatment and information about treatment decisions.

Is there proof that the person has an impairment of, or disturbance in the functioning of, their mind or brain? There must be proof that the person has an impairment of the mind or brain, or some sort of disturbance that affects the way their mind or brain works. If the person does not have such an impairment or disturbance of the mind or brain, they will not lack capacity under the MCA 2005.

Does the assessment record make clear what information the person is able, or unable to understand? For example, does the record make clear whether the person understands salient

information about the nature, purpose and effect of the proposed treatment, including the benefits and risks and the consequences of making no decision at all?

Does the assessment record make clear what information the person is able, or unable, to retain?

A person must be able to retain information long enough to make the decision in question. Some decisions will require information to be retained for a brief period only, others for longer, before a decision is made. The assessment process can be repeated if the information has been forgotten.

Does the assessment record makes clear what information the person is able, or unable, to use or weigh, in order to arrive at a decision? A person does not have to be able to use and weigh every nuance and detail. It is enough that they can use or weigh the salient factors. The assessor should be mindful of the information the person is able to use or weigh, and what information he is unable to. The person may still be able to use or weigh enough relevant information to reach a decision.

Does the assessment record make clear whether the person is able to communicate their decision (by talking, using sign language or by any other means)? This provision is concerned with a person's ability to communicate their decision by any means. It does not encompass a person who is unwilling to communicate their decision.

Does the assessment record make clear whether a person's inability to understand, retain or weigh information, or to communicate their decision by any means, is caused by the impairment or disturbance? The test for capacity under the MCA 2005 requires there to be a causal link between a person's impairment or disturbance, and their inability to make the decision in question. The assessor must have due regard to the presence of other possible factors (such as undue influence).

Is there a conclusion about a person's capacity in the assessment record? By starting with the assumption of capacity, supporting decision-making and following the two-stage test for capacity correctly, the assessor will have a reasonable belief that the person lacks capacity to make the decision in question.

Appendix 3 Procedural Intervention - Wishes and Authorisations

Are details of the person's advance statement of wishes and preferences recorded? An advance statement (otherwise known as a statement of wishes and feelings) is not-binding on a best interests decision-maker, but should be taken into account when working out the best interests of a person who lacks capacity.

Are details of the person's advance decision to refuse medical treatment recorded? A person who is 18 years of age or over, and has capacity, can refuse specified medical treatment for a time in the future when they may lack the capacity to consent to or refuse that treatment.

Is there an advance decision to refuse life-sustaining medical treatment? An advance decision to refuse life-sustaining treatment must be in writing, signed by the person making it, witnessed and contain the words "*even if life is at risk*". If these words are contained in a separate document, that document must also be signed and witnessed.

Is there a registered lasting power of attorney (LPA) for health and welfare? A registered LPA for health and welfare allows the appointed attorney(s) to make decisions about the donor's personal welfare (including healthcare). The LPA document will also make clear whether the attorney(s) have authority to consent, or refuse consent, to life-sustaining treatment.

Is there a deputy for personal welfare? A deputy for personal welfare (including healthcare) may, subject to the scope of the Court's order, make decisions about the person's care or medical treatment, where the person lacks capacity to make those decisions.

If the person is under a standard Deprivation of Liberty Safeguards (DoLS) authorisation, is this recorded? The DoLS are used to authorise the deprivation of liberty of people in care home and hospital settings, who are 18 years of age or more, of unsound mind and lack the capacity to consent to arrangements for their care or treatment in their best interests. People under a standard DoLS authorisation are entitled to the support of a Relevant Person's Representative.

If the person is deprived of their liberty in the community, and this has been authorised by the Court of protection, is this recorded? If a person is deprived of their liberty in the community (for example, sheltered accommodation or supported living in the community), this needs to be authorised by the Court of Protection because it falls outside the scope of the DoLS scheme.

Appendix 4 Procedural Intervention - Best Interests

Is the identity of the best interests decision-maker recorded? Where the decision involves providing medical treatment, the decision maker is the doctor or other member of healthcare staff responsible for carrying out the treatment or procedure.

If an Independent Mental Capacity Advocate (IMCA) is needed, has this been recorded? An IMCA supports and represents a person who lacks capacity to make particular, major decisions (such as providing, withholding or stopping serious medical treatment by an NHS body), where there is no one else appropriate and willing to support them.

Are details of who was consulted about the person's best interests and their views, recorded? As far as it is practicable and appropriate, the decision-maker is under a duty to consult and take into account the views of anyone the person has named as someone to consult in relation to this decision (or similar issues); anyone involved in caring for the person; anyone interested in the person's welfare (such as near relatives and friends); an attorney (if the person has made a health and welfare or a property and financial affairs LPA); or any court-appointed deputy.

Has the best interests decision-maker recorded the relevant circumstances they have taken into account, when making the best interests decision? When working out the person's best interests, the decision-maker should try to identify all the issues that would be most relevant to the decision (for example, the person's clinical needs, the benefits and burdens of any proposed treatment and other factors which may be relevant).

Is there evidence that the decision-maker has permitted and encouraged the person to be involved in the decision-making process, as far as they are able to? There is a duty to permit and encourage a person who lacks capacity, to take part in the decision-making process as far as they are able to.

If the decision is about life-sustaining treatment that decision must not motivated by a desire to bring about the person's death. Life-sustaining treatment means treatment which is necessary to sustain life. No person can have the motive of causing death, regardless of what would be in the person's best interests.

Has the decision-maker tried to ascertain the person's past and present wishes and feelings? A person's wishes should be central to the best interests decision-making process. The decision-maker should consider matters from the person's point of view. A person's wishes, if these can be confidently ascertained, should be given great respect.

Has the decision-maker tried to ascertain other factors which the person, if they had capacity, would have taken into account? For example, the decision-maker should take into account factors such as the person's emotional bonds, family obligations or concern for others.

Does the record make clear what the outcome is and how the best interests decision has been reached? The approach should be evidence-based. The decision-maker should weigh relevant factors, identify the options and choose the best outcome for the person, having regard to options which restrict the person's freedom as little as possible.

Appendix 5 Equality Impact Assessment

	Mandatory Questions	Yes/No/NA	Comments
1.	Does the Policy affect any group less or more favourably than another on the basis of:		
	Age?	No	
	Disability?	No	
	Gender?	No	
	Gender identity?	No	
	Marriage or civil partnership?	No	
	Pregnancy and maternity or paternity?	No	
	Race?	No	
	Religion or belief?	No	
	Sexual orientation?	No	
2.	Is there any evidence that any groups are affected differently by the Policy and if so, what is the evidence?	No	
3.	Is any impact of the Policy likely to be negative?	No	
4.	If any impact of the Policy is likely to be negative, can the impact be avoided and if so, how?	NA	
5.	If a negative impact can't be avoided, what, if any, are the reasons the Policy should continue in its current form?	NA	
6.	Where relevant, does the Policy support the FREDA principles: Fairness, Respect, Equality, Dignity and Autonomy?	Yes	

If you have identified a potential discriminatory impact of this Policy, please contact the Chief of Staff.